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_____

Greetings! We are glad that you have chosen us to provide your medical care. You have a New Patient appointment with _____ on _____ at _____. These are the papers you will need to fill out. Please bring these forms with you when you come in for your appointment. Please arrive at least 30 minutes prior to the scheduled appointment time. You will need to bring your Insurance card and Drivers license/picture ID with your current address on it with you.

If you are unable to arrive on time (30 minutes), we will need to reschedule your appointment for another day. Please go to our website: drrobertnolanjr.vpweb.com to view the HIPPA. (it has its own page) Then sign the HIPPA form. If you are unable to view on the website we will supply you a copy to read in the office.

Please note that for any reason you need to cancel or reschedule this or future appointments, you must call us at least 24 hours in advance in order to avoid incurring a charge of $50.00 for the missed or rescheduled appointment.

Your attention to these important matters will enable us to serve you better.

Thank you and welcome to our office!

Robert B. Nolan Jr., M.D.

Please Note: So that we may maintain the most up to date and accurate information on our patients we will request that you review and update this form at least once a year.

PATIENT INFORMATION
Patient Name:

First_____MI____ Last_____SS #_____

DOB _____Marital Status: ☐ Single ☐Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Life Partner

Preferred Language: English _____ Spanish _____ Other _____

Do you have communication difficulties / special needs? Need an Interpreter?____Yes____No____Unable to determine

Hearing Loss Reading Difficulty Sight Impaired Other? _____Yes_____ No

If yes, please list: _____

Address: _____Apt#_____

City _____ State _____ Zip Code _____

Phone: Home _____ Cell _____ Work _____

Email: _____

Best Contact Method: ☐Home ☐ Cell ☐ Work ☐ Mail ☐ Email
By checking one of these boxes for Best Contact Method, I agree to receiving Correspondence

Employment Status: ☐ Full-Time ☐ Part-time ☐ Unemployed ☐ Student ☐ Disabled ☐ Retired

Employer/School: _____

Referred by:_____

What is your current gender identity?

☐ Male
☐ Female
☐ Transgender Male/Trans Man/FTM
☐ Transgender Female/Trans Woman/MTF
☐ Genderqueer/Nonbinary
☐ Additional Category
(please specify)_____

What sex were you assigned at birth?

☐ Male
☐ Female
☐ Intersex

What is your race? Check all that apply

☐ White
☐ Black or African American
☐ American Indian or Alaska Native
☐ Asian Indian
☐ Chinese
☐ Filipino
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Other Asian
☐ Native Hawaiian
☐ Samoan
☐ Other Pacific Islander
☐ Patient unable to respond

Are you of Hispanic, Latino/a or Spanish Origin? Check all that apply.

☐ No, not of Hispanic, Latino/a or Spanish origin
☐ Yes, Mexican, Mexican American, Chicano/a
☐ Yes, Puerto Rican
☐ Cuban
☐ Yes, Another Hispanic, Latino, or Spanish origin
☐ Patient unable to respond

Insured's Information or Financially Responsible Party

☐ **Same as Patient Information** (*If different, please complete section below)*

Name: First _____ MI _____ Last _____

Relationship: Spouse Parent Guardian Other (please specify): _____

Address: _____ Apt # _____

City _____ State _____ Zip Code _____

Phone:

Home _____ Cell _____ Work _____

Email Address: _____

Employer _____

Date of Birth of Insured: _____

Preferred Pharmacy Name _____

Address _____

Phone Number _____

_____ **I Acknowledge that if I fail to give 24 hour notice or if I miss an appointment**
initials **I will be billed a fee of $50.00.**

Lab/Diagnostic services:

I understand that I may receive a separate bill if my medical care includes labs and other diagnostic services. I further understand that I am financially responsible for any co-pays, deductibles and co-insurance due for these services if they are not reimbursed by my insurance. _____
initial

IN ORDER TO CONTROL OUR COSTS OF BILLING WE REQUEST THAT OFFICE VISITS BE PAID AT THE TIME SERVICE IS RENDERED. WE WOULD RATHER CONTROL OUR BILLING COSTS THAN BE FORCED TO RAISE OUR FEES. PLEASE BE SURE TO ALWAYS BRING A LIST OF YOUR CURRENT MEDICATIONS WITH YOU AT EACH VISIT.

PLEASE PRESENT ALL OF YOUR INSURANCE CARDS TO THE RECEPTIONIST.

I authorize the release of any medical information necessary to process insurance claims filed on my behalf.
I authorize payment of medical benefits to be made directly to the physician for services performed. I also certify that all of the information provided is complete and accurate.

_____ _____

Signature of Patient or Responsible Party **Date**

BY SIGNING BELOW I ACKNOWLEDGE THAT I HAVE ***REVIEWED*** A COPY OF THE HIPPA PRIVACY PRACTICE NOTICE.

I UNDERSTAND THAT I CAN REQUEST A COPY FOR MY RECORDS.

PATIENT NAME _____
(PRINT PLEASE)

I AUTHORIZE DR.NOLAN'S OFFICE TO RELEASE INFORMATION TO THE FOLLOWING PEOPLE REGARDING MY HEALTH CARE:

SPOUSE: _____
MOTHER: _____
FATHER: _____
CHILDREN: _____
OTHER: _____

IN CASE OF AN EMERGENCY, MY EMERGENCY CONTACT WOULD BE:

NAME: _____
HOME PHONE: _____
CELL PHONE: _____
WORK PHONE: _____
RELATIONSHIP: _____

I AUTHORIZE DR. NOLAN'S OFFICE AND ALL THE ENTITIES ASSOCIATED WITH HIS OFFICE TO CALL ME AT

HOME ____ WORK _____
CELL_____ OTHER _____

PATIENT SIGNATURE_____
DATE_____

Name_____

MEDICAL HISTORY FORM

Personal History:

1. Occupation: Yours_____Spouse's_____
2. Marital Status: ☐ Single ☐Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Life Partner
3. Place of employment_____
4. Education: (circle level completed)
   High School 9 10 11 12 College 1 2 3 4 Masters Ph.D. Others
5. Are you sexually active: ☐Yes ☐No If yes, what type of contraception used
6. Presently planning pregnancy? ☐ Yes ☐ No
7. Lesbian, gay or homosexual ☐ Straight or heterosexual ☐ Bisexual ☐ Something else ☐ Don't know ☐
8. Hobbies: list_____
9. Smoking history: Packs each day? _____ For how many years? _____
10. Drinking history: Holidays only _____Weekends only_____ After dinner only
    Rarely _____ Moderately _____ Frequently _____
    (a) Have you ever been an alcoholic? _____
11. Caffeine history:_____
12. List the individuals that live in your home: _____
13. How much exercise do you get (walking, jogging, bicycling, swimming, golf, tennis, other: circle please)
    Min each day? _____ Hours per week? _____ Moderate occupational and recreational exercise? _____
    Sedentary work and light exercise only? _____
14. What additional information should the doctor have about you?_____
    _____
    _____
15. Stress in your life: (circle) Mild Moderate Severe
16. Comments: _____
    _____
    _____
17. Do you take a calcium supplement? ☐ Yes ☐ No
18. Do you wear seat belts routinely? ☐ Yes ☐ No
19. Last Dental exam. _____

List other Physicians seen in the last two years and why: _____
_____
_____

Past Medical History:

1. Illnesses & operations (requiring hospitalization, list problem and year)
   (a)_____(d)_____
   (b)_____(e)_____
   (c)_____(f)_____
2. Psychiatric History
   (a)_____(d)_____
   (b)_____(e)_____
   (c)_____(f)_____
3. Accidents (list broken bones/ injuries, etc.
   (a)_____(d)_____
   (b)_____(e)_____
   (c)_____(f)_____

4. Allergies (have you had reactions to any of the following medications (yes or no) and describe the reaction:
   For example: "Rash, asthma, hives, blackout, GI upset **Latex Allergy Y / N**
   (a) No Know Allergies ____________ (e) Codeine ____________
   (b) Penicillin ____________ (f) Anesthetics ____________
   (c) Sulfa ____________ (g) Other____________
   (d) Aspirin ____________ (h) Other ____________
5. Pregnancies ________ Miscarriages ________ Weight of largest child at birth ____________
6. Medications (list all you are now taking or have taken (in the past month) and indicate how often you have take them): Please bring all your medication with you to each visit.

____
____
____
____
____
____
____
____
____
____
____
____
____

   How much Aspirin ____________
   Laxatives ____________
   Oral Contraceptive ____________
   Sleeping Pills ____________
7. Last Cholesterol level ____________
8. Last time stool was checked for occult blood ____________
9. How often do you feel lonely or isolated from those around you?
   - ☐ Never
   - ☐ Rarely
   - ☐ Sometimes
   - ☐ Often
   - ☐ Always
10. Has lack of transportation kept you from medical appointments, meeting, work, or from getting things needed for daily living?
    - ☐ Yes, it has kept me from medical appointments or from getting my medications
    - ☐ Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need
    - ☐ No
11. How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?
    - ☐ Never
    - ☐ Rarely
    - ☐ Sometimes
    - ☐ Often
    - ☐ Always

MEDICAL HISTORY FORMS (CONTINUED)

Review of Systems: Review the list below and CIRCLE any number that describes a problem you are currently having and UNDERLINE those problems you have frequently in the past.

1. Headaches
2. Seizures or fits
3. Numbness or tingling in hands, feet, arms, or legs
4. Weakness in hands, feet, arms, or legs
5. Difficulty maintaining balance
6. Dizziness
7. Fainting or blackout spells
8. Strokes
9. Ringing in ears
10. Difficulty with hearing
11. Difficulty with vision
12. Double Vision
13. Difficulty on smelling things
14. Excessive sneezing
15. Trouble breathing through nose
16. Nose bleeds
17. Change in voice
18. Shortness of breath at night
19. Shortness of breath while walking
20. Swelling of ankles or feet
21. Palpitations
22. Chest pain or tightness in chest
23. Heart attacks
24. High Cholesterol
25. Swelling in legs
26. Cough
27. Cough up blood
28. Wheezing during breathing
29. Sugar diabetes
30. High blood pressure
31. Night sweats
32. Continuous fever for greater than 5 days
33. Nausea, chronic
34. Trouble with swallowing
35. Vomiting
36. Diarrhea, chronic
37. Constipation, chronic
38. Vomit blood
39. Blood in bowel movements
40. Black, loose bowel movements
41. Stomach pains
42. Jaundice (yellow skin)
43. Stomach ulcers
44. Hemorrhoids
45. Weigh loss
46. Weight gain in past year
47. Loss of appetite
48. Frequent urination or passing water
49. Urination at night
50. Pain on urination
51. Pus or milky color of urine (water)
52. Blood in urine
53. Pass a stone in urine
54. Reduction in force or size of urine
55. Difficulty starting urine stream
56. Leakage of urine
57. Difficulty with erection
58. Difficulty with ejaculation
59. Discharge from penis
60. Onset of menstruation (age)_____
61. Duration of menstruation in days _____
62. Length of interval between periods _____
63. Bleeding between periods
64. Painful periods
65. Irregular periods
66. Last menstrual period_____
67. Last pelvic_____
68. Vaginal discharge
69. Last PAP smear_____
70. Any sexual concerns_____
71. Back pain – high
72. Back pain – low
73. Change in glove size, shoe size, or hat size
74. Muscle cramps in arms, legs, hands, or feet
75. Pain in legs while walking
76. Joint swelling
77. Pain in hands or feet on cold weather
78. Joint pain
79. Skin rash
80. Dry skin
81. Increase in hair growth
82. Loss of hair
83. Increase in oiliness of skin
84. Hives
85. Excessive sweating
86. Prefer hot water
87. Prefer cold water
89. Skin pallor (paleness)
90. Breast discharge
91. Lumps in breast
92. Painful breast
93. Last Mammogram _____
94. Excessive blistering after sun exposure
95. Change in facial appearance
96. Easy bruising
97. Excessive bleeding after cutting skin
98. Crying spells
99. Insomnia
100.. Mood swings
101. Nervousness
102. Difficulty with memory
103. Problem with thinking clearly
104. Chronic fatigue or weakness
105. Depression and anxiety

Weight age 20_____

Weight 1 year ago_____

Weight now _____

FAMILY HISTORY	Age	State of Health	Cause of Death
Father			
Mother			
Brothers			
Sisters			
Spouse			
Children			
(circle one) M F			
M F			
M F			
M F			

WHO IN YOUR FAMILY HAD:	Father	Mother	Sister (s)	Brother (s)	Other
1. Cancer					
2. Tuberculosis					
3. Allergies or asthma					
4. Strokes					
5. Nervous breakdown					
6. Suicide					
7. Headaches					
8. Diabetes					
9. Arthritis					
10. Heart attack					
11. High blood pressure					
12. Kidney stone					
13. Ulcers					
14. Stroke or heart attack prior to age 60					

Form #1100

ADULT IMMUNIZATIONS DATE

Tetanus _____

Pneumonia vaccine (pneumovax) _____

Hepatitus B _____

LIVING WILL: State law allows you to formulate advance directives. Advance directives are documents that enable you to give direction about your future medical care. If you are interested in learning more please ask for the handout we have to provide additional information.

☐ Yes ☐ No Do you have a Living Will? If Yes, please discuss with your M.D. & provide a copy for your medical records.